

of dressing-forceps. No untoward symptoms were developed until the evening of the fourth day, when a convulsion ensued because of pent-up pus, and after the removal of the cause no further trouble followed. The lesson to be derived from the study of the case is the necessity of maintaining free drainage, thus preventing an abscess from extending in the brain and becoming fatal.

SYPHILIS OF THE NERVOUS SYSTEM.—Dr. S. G. Webber read before the Boston Society for Medical Improvement, an abstract of a paper which is to appear in the coming volume of the Boston City Hospital Report. The following are some of the conclusions that he has reached: There is no pathognomonic symptom of syphilis of the nervous system; the diagnosis must be made by grouping the manifestations, and viewing them and their history as a whole. Among the more frequent peculiarities is irregularity of the phenomena and their ephemeral nature, disappearing to come again. Headache is the most common and the earliest symptom of the central nervous system, and gives timely warning that the subsequent dangers may be avoided. Its characteristics are severity, with remissions or intermissions. The pain is persistent, or returns again and again. It is often, but by no means always, most severe in the latter part of the day or night. It may be limited or general, unilateral or bilateral. Nausea and dizziness are generally absent. The ocular nerves are more frequently paralyzed than the other cranial nerves, and in general, paralysis is preceded by headache or trifacial neuralgia. Hemiplegia is less likely to be sudden than to occur gradually, to be intermittent, to be preceded by headache, and to be accompanied by numbness of the same parts. Syphilis of the spinal cord is less common than cerebral syphilis. Its prognosis is much less favorable, and it also has no pathognomonic symptom. Perhaps many of the cases of locomotor ataxia reported cured were really cases of syphilitic neuritis. Syphilitic neuritis of peripheral nerves is not common, and is not easily recognized as such. The time at which nervous symptoms appear after the primary sores varies in Dr. Webber's cases from two and a half months to twenty-five years; the majority coming, as is reported by other observers, within three years. The reader hesitated to say much of prognosis. If headache exists alone, or if the symptoms are variable and intermittent, the prospect is fair. If there be organic change, recovery is doubtful, although the disease may be arrested. Some cases must be treated, at least intermittently, for many years, even after symptoms have disappeared. Slight cases may be treated with fifteen or twenty grains of iodide of potassium three times daily, continued many weeks after apparent recovery. In serious cases temporizing is dangerous, and iodide of potassium and mercury should be given in sufficient doses. Of the iodide, from seventy to two hundred and twenty-five grains have been given in the cases reported. Larger doses have been given by the

reader, but without benefit and without harm. In some cases small doses have been badly borne, but on increasing the dose the unpleasant symptoms have disappeared.—*Boston Med. and Surg. Jour.*, No. 12.

LOCOMOTOR ATAXY, WITHOUT DISEASE OF THE POSTERIOR COLUMNS OF THE SPINAL CORD.—Dr. A. Hughes Bennett read notes of this case before the Clinical Soc. of London, Feb. 27th. The patient during life presented all the prominent symptoms of tabes dorsalis, while after death the posterior columns and cornua of the spinal cord were found without a trace of disease. From this fact, important physiological and pathological conclusions were drawn. The patient, a man, aged forty-eight, suffered from all the usual symptoms of locomotor ataxia, including inco-ordination of movement, without loss of muscular power, a typical ataxic gait, Romberg's symptom, impaired and retarded sensibility of the lower extremities, lancinating pains, and loss of the knee-jerk phenomena. After death evidences of general acute cerebritis were found, with patches of recent softening. In the medulla oblongata, there was a mass of sarcomatous infiltration occupying its posterior and central aspects; with the exception of one anterior cornu in a limited portion of the lumbar region, the spinal cord was perfectly normal throughout, as were also the posterior cornu, and roots within the circle of the spinal membranes. Outside these the posterior roots in the dorsal and lumbar regions were found involved in a mass of sarcoma, which extended as far upwards as the cervical portion of the cord. In the lumbar region the anterior roots were implicated, but only to a very limited degree. Microscopic preparations and drawings illustrating these facts were shown at the meeting. In commenting on this fact, special attention was directed to the pathological and clinical phenomena. It was pointed out that the patches of central softening were probably quite recent, and due to the acute cerebritis, which supervened shortly before death. The sarcomatous growth in the medulla was stated to be a rare pathological condition; and the absence of pronounced bulbar symptoms was explained by the supposition that the morbid material had infiltrated the normal structures, without causing their serious degeneration. Although one anterior horn was implicated, and some of the anterior roots slightly involved in the disease, it was evident that this had caused few symptoms during life, as the motor power was unimpaired, there was no muscular wasting, and the retinal reactions were normal. The clinical point illustrated by this case, to which it was the object of the paper specially to direct attention, was the relation which existed between the spinal symptoms and the lesions in the posterior roots of the cord. It was pointed out that the patient during life suffered from all the prominent symptoms of tabes dorsalis, and presented a fairly typical clinical picture of what was understood of that disease. It was then stated that the universal belief was that the essential lesion of locomotor ataxy